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IN THE

Supreme Court of the United States

METROPOLITAN LIFE INSURANCE COMPANY and LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK & COMPANY,

Petitioners,

v.

WANDA GLENN,

Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF OF *AMICUS CURIAE* THE AMERICAN COUNCIL OF LIFE INSURERS IN SUPPORT OF PETITIONERS

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STATEMENT OF INTEREST[1]

The American Council of Life Insurers ("ACLI") is the nation's largest life insurance trade association, representing the interests of 353 member companies operating in the United States. ACLI member companies are the leading providers of financial and retirement security products covering individual and group markets. They provide life, disability income and long-term care insurance, annuities, pension products and reinsurance. In the United States, ACLI members account for 93% of the life insurance industry's total assets, 93% of life insurance premiums, and 94% of annuity considerations. Insurance policies issued by ACLI members include employer-sponsored group disability income insurance policies and group life policies. Annuities issued include group annuities issued to employer-sponsored retirement plans. The vast majority of products sold by ACLI members in the group employee benefits market are subject to the requirements of the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"). ACLI advocates the interests of life insurers and their millions of policyholders and beneficiaries before federal and state legislators, state insurance departments, administration officials, federal regulatory agencies and the courts.

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1. In compliance with Rule 37.6, *amicus curiae* states that no person or entity other than *amicus curiae*, its members or its counsel made a monetary contribution intended to fund the preparation or submission of this brief, and no attorney for any party authored this brief in whole or in part. In compliance with Rule 37.3(a), *amicus curiae* states that petitioners have filed with the Clerk a consent to the filing of *amicus* briefs, and that respondent has separately consented to the filing of this brief.

Accordingly, ACLI and its members have a substantial interest in the two questions the Court has certified in this case:

> 1. Whether the mere fact that the claim administrator of an ERISA plan also funds the plans benefits, without more, constitutes a "conflict of interest" that must be weighed in a judicial review of the administrator's benefit determination; and
>
> 2. If an administrator that both determines and pays claims under an ERISA plan is deemed to be operating under a conflict of interest, how should that conflict be taken into account on judicial review of a discretionary benefit determination?

Resolution of these questions will have significant ramifications for the employee benefits industry. Given the extensive and vital involvement of ACLI's members in the employee benefits field regulated by ERISA, ACLI is well positioned to address these questions, particularly with respect to employee benefit plans funded through the purchase of insurance. A proper understanding of both the functional organization of insurers and the manner in which they underwrite group policies and spread risks is a fundamental predicate to resolving these questions. An overly-simplistic view of the economic realities of the business of insurance has resulted in several Circuit Courts of Appeals imposing a heightened standard of review under the mistaken rationale that a company administering claims on behalf of an ERISA plan cannot also fund the plan's benefits without a "conflict of interest," even when no such conflict has been shown in fact to exist or to have

motivated a particular claims decision. They have disregarded the fact that ERISA's statutory and regulatory framework expressly contemplates and permits a company to provide claim administration services while also funding the benefit claims. They also diminish the significant procedural safeguards ERISA provides that allow a benefit denial stemming from an actual improper motive to be readily detected.

SUMMARY OF ARGUMENT

ACLI respectfully submits that a "conflict of interest" does not exist merely because a company providing claims administration services also funds plan benefits.[2] Without more, no heightened standard of judicial review is necessary. Where the plan contractually grants a company administrating claims the discretion to interpret plan terms and render claim decisions, a traditional deferential standard of review should apply in the absence of a showing that the potential conflict of interest is more than hypothetical and actually tainted the benefit determination. Underlying the decisions of those Circuits which have held otherwise is a blanket and overly-simplistic assumption that providing the claims services, benefit payment and funding contemplated by the contract between an insurer and an employer results in lower profits for the insurer. For a number of reasons, this assumption is fundamentally

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2. The questions presented in this case regarding potentially conflicted administrators and fiduciaries pertain not only to insured plans, but also arguably to self-funded and self-administered plans, and even self-funded plans administered by an outside party that is paid by the plan sponsor. Herein, ACLI focuses primarily on insured plans.

flawed, contrary to the express provisions of ERISA, and detrimental to the cost-effective delivery of benefits contemplated by its drafters.

First, life insurers are in the business of developing, funding and administering retirement and other financial security products at competitive prices with an appropriate return to their stockholders or, in the instance of mutual life insurers, their policyholders. As with any other company, an insurer succeeds in the market by providing quality products and services that are appropriately priced. Accordingly, an insurer's economic success will depend on its ability to accurately underwrite the policies it issues — not on its denial of valid claims.

Second, the premium that an insurance company charges for a particular policy is the product of sophisticated underwriting practices, grounded in complex applications of mathematics, economics, finance, probability, and statistics, that allow insurers to assess the risk of an insured event occurring and to correctly price the cost of insuring that event.[3] In calculating

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3. The importance of underwriting to life insurers is evidenced by the rigorous training and credentialing of their actuaries. In the United States, the Society of Actuaries administers a battery of exams and requires, for associate status, passing five preliminary examinations, providing proof of academic experience in economics, corporate finance, and applied statistics, and completing an eight-module self-learning series. Fellows of the Society must complete an additional three training modules, two exams, and a special fellowship admission course. *See* Society of Actuaries, Admission Requirements to the SOA,

(Cont'd)

premiums, underwriters determine not only the revenue needed to cover the anticipated claims experience for the group policy, but also an additional "risk charge" as a cushion should actual claims exceed the anticipated claims experience, contribution to necessary claim reserves and contribution to company surplus. Thus, premiums ordinarily will provide sufficient revenue to pay claims that are validly within the risks that the company assumed in issuing the group policy.

Third, group contracts between insurers and employers generally are subject to annual renewal and, upon renewal, premium adjustments can be made if actual claims experience under a particular group policy

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(Cont'd)

Spring 2008 Basic Education Catalog (2008), http://www.soa.org/education/course-catalog/spring-exam-session/2008/edu-admission-req.aspx (last visited Feb. 28, 2008). In order to sign statements of actuarial opinion, U.S. actuaries must be members of the American Academy of Actuaries, which requires membership in one of the recognized actuarial societies (*e.g.*, the Society of Actuaries), at least three years of full-time equivalent experience in responsible actuarial work, and continuing education certification. *See* American Academy of Actuaries, Academy Policies: Membership Requirements, *American Academy of Actuaries: 2008 Yearbook*, 67-69 (2008), *available at* http://www.actuary.org/yearbook/index.asp; American Academy of Actuaries, *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States*, 5-7, 10 (2008), *available at* http://www.actuary.org/qualstandards/qual.pdf. Some pension-related filings to the Internal Revenue Service and the Pension Benefit Guaranty Corporation require the signature of an Enrolled Actuary, who is required to pass two additional examinations. *See* 20 C.F.R. § 901.13(c)-(d); Joint Board Examination Program, http://www.irs.gov/taxpros/actuaries/article/0,,id=97444,00.html (last visited Feb. 28, 2008).

exceeds the originally anticipated claims experience. These adjustments include prospective experience rating, whereby the premiums charged in subsequent years can be adjusted to offset excess claims experience in prior years. For larger group policies, retrospective experience rating also may be used, whereby an insurer can recoup a portion of the excess claims paid under a particular group policy from the policyholder (and/or issue refunds to the policyholder if actual claims are less than the anticipated claims experience). Additionally, insurers have the option, apart from these measures, of "reinsuring" a group policy. Through the purchase of reinsurance, an insurance company can transfer specified risk liability to one or more other insurance companies, thus limiting its own risk under the group policy.

Accordingly, and as several Circuits have properly concluded, the outcome of one particular claim is unlikely to have any significant effect on an insurer's profitability. Indeed, if so remote and minute an economic interest qualifies as a potential conflict of interest, the courts would be hard-pressed to find any actor in the employee benefits process who could not be said to have an economic conflict of interest — whether it be the beneficiary's treating physician, who has an economic interest in retaining his/her professional relationship with the beneficiary, or an outside third party claim administrator of a self-funded plan paid by the plan or its sponsor, who has an interest in retaining its commercial relationship with the plan sponsor.

Additionally, the premise upon which the first certified question is based — that an insurance company "wears two hats" in the employee benefits process, is itself an over-generalization that ignores the functional organization of an insurance company. Claims personnel, who process and determine benefit claims, operate separately and independently from other staff who underwrite policies, manage company reserves and otherwise oversee the financial health of the insurer. Claims staff wear only "one hat" — that of determining the validity of the claim. In the exercise of this function, such staff have a fiduciary duty to the beneficiaries of the plan. They also must adhere to regulatory requirements under both ERISA and state insurance law for proper processing of claims, and their administration of claims is subject to extensive and detailed examination by state insurance regulators.

Finally, ACLI notes that ERISA itself contemplates and expressly permits plan fiduciaries to both make benefit determinations and fund the benefits paid while imposing substantial requirements to ensure the protection of a beneficiary's interests, including the provision of information that may be needed to dispute an adverse claims decision.

With respect to the second certified question, where the claims administrator is granted discretion under the terms of the plan, a traditional deferential standard of review should apply in the absence of some showing that the conflict of interest actually tainted the benefit determination. Such an approach is most consistent with this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). *Firestone* indicates that

where a plan confers discretionary authority to determine eligibility for benefits or construe plan terms upon a fiduciary "who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)). Clearly, this statement means that a court must consider the conflict in assessing whether there has been an abuse of discretion, but it does not suggest that the discretionary standard of review itself is affected. This statement must be read in light of the common law of trusts, upon which *Firestone* is predicated. Under the common law of trusts, the abuse of discretion standard is not altered merely because a trustee is operating under an apparent conflict of interest. Rather, it must be shown that the trustee's decision was affected by that conflict. *See* Restatement (Second) of Trusts § 187 cmt. e (1959) (court will not interfere with a trustee's exercise of discretionary power unless the trustee "acts dishonestly, or with an improper even though not a dishonest motive, or fails to use his judgment or acts beyond the bounds of a reasonable judgment. The mere fact that . . . the court would have exercised the power differently, is not a sufficient reason"). For this reason, the various other approaches adopted by the lower courts, which range from applying "heightened scrutiny," *i.e*, a "less deferential" standard of review, to a *de novo* review, do not comport with *Firestone* and should be rejected.

ARGUMENT

In the 19 years since *Firestone* was decided, the U.S. Circuit Courts of Appeals have been fragmented on the issue of whether the mere fact that an entity both makes claim determinations and pays the claims, without more, creates a "conflict of interest" sufficient to alter the standard of judicial review. The First and Seventh Circuits have concluded that this fact does not create a conflict of interest and is irrelevant on judicial review. *Wright v. R.R. Donnelly & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74-75 (1st Cir. 2005); *Pari-Fasano v. ITT Hartford Life & Accident Ins. Co.*, 230 F.3d 415, 418 (1st Cir. 2000); *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999); *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998). Others have held that this fact should be considered on judicial review only if the beneficiary can demonstrate not merely that a potential conflict of interest exists, but that the purported conflict actually influenced the benefit determination. *Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89, 92 (2d Cir. 2000); *Sahulka v. Lucent Techs., Inc.*, 206 F.3d 763, 768 (8th Cir. 2000); *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160 (8th Cir. 1998) (claimant must present "material, probative evidence demonstrating that (1) a palpable conflict of interest or a serious procedural irregularity existed, which (2) caused a serious breach of the plan administrator's fiduciary duty to [the claimant]," *quoted in Barnhart v. UNUM Life Ins. Co. of Am.*, 179 F.3d 583, 587-88 (8th Cir. 1999)). Others, including the Sixth Circuit below, have held that this fact does constitute a conflict of interest that must be weighed on judicial

review. *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 965-66 (9th Cir. 2006) (*en banc*); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 387-88 (3d Cir. 2000).

The Circuits are similarly fragmented with respect to the manner in which the standard of judicial review is applied when the claims administrator is deemed to be operating under a conflict of interest. The various approaches defy easy classification. Several Circuits, including the Sixth, have adopted approaches generally referred to as the "sliding scale" approach, under which the degree of deference shown by the court varies inversely with the seriousness of the conflict. *Abatie*, 458 F.3d at 967 (rejecting the "sliding scale" label but adopting a similar approach); *Pinto*, 214 F.3d at 392; *Vega v. National Life Ins. Servs. Inc.*, 188 F.3d 287, 297 (5th Cir. 1999) (*en banc*); *Barnhart v. UNUM Life Ins. Co. of Am.*, 179 F.3d 583, 587 (8th Cir. 1999). The Tenth and Eleventh Circuits shift the burden of proof to the conflicted fiduciary to establish the reasonableness of the benefit determination. *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006 (10th Cir. 2004); *HCA Health Servs. of Ga. Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 993-95 (11th Cir. 2001). The Second Circuit applies a *de novo* review to benefit decisions made by a conflicted fiduciary. *Pulvers*, 210 F.3d at 91.

ACLI respectfully submits that the approach adopted by the First and the Seventh Circuits is most consistent with the underlying economic realties of the insurance market, ERISA's statutory and regulatory framework and the Court's precedent. The mere fact that an insurer administers, determines and funds claims, without more, should not affect the application of a traditional discretionary standard of review.

I. THE MERE FACT A COMPANY BOTH MAKES BENEFIT DETERMINATIONS AND PAYS CLAIMS, WITHOUT MORE, DOES NOT CONSTITUTE A CONFLICT OF INTEREST SUFFICIENT TO AFFECT THE STANDARD OF REVIEW.

A. The Economic Realities Of The Insurance Industry Establish That A Company That Both Determines And Pays Claims Does Not Operate Under A Conflict Of Interest.

1. Market Forces Create An Economic Incentive For Insurers To Pay Valid Claims.

Insurers have an economic incentive to adjudicate group benefit claims fairly and to pay valid claims. A company, irrespective of the nature of the products or services it provides, only succeeds in the marketplace by providing quality products and services that are appropriately priced. Accordingly, an insurer's economic success will depend on its effectiveness in accurately underwriting the policies it issues — not through denial of valid claims.

While those unfamiliar with insurance practices and regulation might assume that denying valid claims is financially advantageous, engaging in such a practice will seriously undermine the marketability of the company's products, thereby negatively impacting its financial condition as customers shift to companies that fairly pay claims pursuant to the terms of the issued policy, and justifiably warrant corrective regulatory action. The First and Seventh Circuits have properly recognized that

market forces in the employee benefits arena provide competing incentives that belie concerns that an insurer is predisposed to deny valid claims. As noted by the First Circuit, "an employer would not want to keep an overly tight-fisted insurer," as the purpose in "having a benefit plan is to please employees, not to result in the employer's bad reputation." *Doyle v. Paul Revere Life Insurance Co.*, 144 F.3d 181, 184 (1st Cir. 1998). As the Seventh Circuit has further noted:

> Companies ... that sponsor ERISA plans are customers who choose which group insurance policies they will use to fund their plans. ... [These employers] want their employees satisfied with their fringe benefits. These corporate employers have the sophistication and bargaining power necessary to take their business elsewhere if an insurer ... consistently denies valid claims. In the long run, this type of practice would harm an insurer by inducing current customers to leave and by damaging its chances of acquiring new customers.

Mers, 144 F.3d at 1021.

Indeed, the structure of insured plans, in which employees participate voluntarily and also typically contribute toward plan premiums, undercuts the argument that fiduciaries will improperly deny valid claims. Where employees contribute to a plan, whether funding it entirely or paying a portion of the premiums, market forces are at work:

> The Plan is a voluntary employee-funded entity, and market forces are at work. If [the insurer] denies claims that Plan participants

> as a group view as valid, those employees will be inclined to withdraw from the plan, thus reducing [the insurer's] role (and presumably its compensation). By the same token, if [the insurer] awards benefits that are viewed as undeserved, Plan participants will experience an increase in their premiums and thus be inclined to withdraw from the Plan (again reducing [the insurer's] role and remuneration). Either way, the structure of the Plan furnishes an incentive for [the insurer] to be unbiased in its handling of claims. This is telling, for courts should not lightly presume that a plan administrator is willing to cut off its nose to spite its face.

Leahy v. Raytheon Co., 315 F.3d 11, 16 (1st Cir. 2002). (Plan funded by employees).

2. The Underwriting Process Ensures That Sufficient Revenue Is Available To Pay Valid Claims.

Proper construction of ERISA requires an understanding of the employee benefits market that it was intended to regulate, including the process of underwriting. The goal of all group underwriting is "to assess risk accurately and equitably, and to calculate an appropriate premium to pay for the coverage." Jane Lithcap Brown et al., Life Office Management Association, Inc., *Insurance Administration* 178 (2d ed. 2002). The success and solvency of an entity issuing group insurance is contingent upon the long run adequacy of the premium rates charged for that group coverage. Burton T. Beam, Jr., *Group Benefits: Basic Concepts and Alternatives* 232 (5th ed. 1993).

Premium rates consist of four basic components: (1) the rate necessary to support the cost of expected or anticipated claims (referred to as a "net premium rate"); (2) a contribution to the company's contingency reserves to provide a cushion against unanticipated or catastrophic amounts of claims (referred to as a "risk charge"); (3) an adjustment for expenses occurred in administering the group policy, such as commissions, premium taxes and other costs associated with acquiring and servicing the group policy; and (4) a contribution to the company's surplus or profit. *Insurance Administration*, *supra*, at 178; *Group Benefits: Basic Concepts and Alternatives*, *supra*, at 232.

In assessing the risk of future claims posed by a particular employee group, an underwriter will consider a multitude of factors, including the reason for the group's existence, the type of group, the stability of the group's composition, the size of the group, the type of industry in which the group works, the geographic location of the group, the level of group participation in the coverage, and group characteristics such as age spread within the group. *Insurance Administration*, *supra*, at 179-85. Underwriters also will consider the expected "persistency" of the group policy, *i.e.*, the probability that the coverage will be continued over a period of years. Persistency is an important factor because a policy in force for a sustained period is more likely to overcome the effects of a single year of excess claims. *Id.* at 185-86.

In calculating an appropriate premium rate, underwriters can use three different approaches: manual rating, experience rating or a blended method that combines both manual and experience rating. Manual rating essentially is the process by which rates are

established for broad classes of groups based on the risk characteristics presented by the groups. *Id.* at 195-96. Manual rating does not consider the prior claim experience for a particular group, and is used where such information is unavailable. In determining the net premium rate (the rate necessary to cover the cost of anticipated claims), insurance companies may rely on their own past claims experience to determine the frequency and severity of future claims, or rely on aggregate data regarding group insurance compiled by sources such as the Society of Actuaries. *Group Benefits: Basic Concepts and Alternatives*, *supra*, at 232.

In experience rating, a particular group's own past claim experience is used to calculate premium rates. Experience rating is based on the assumption that a group's claim experience is likely to remain relatively constant from year to year. Although in some years, a group may have higher or lower numbers of claims and dollar amounts of the claims, the likelihood is high that a group with a relatively stable composition will experience roughly the same level of claims from one year to another. *Insurance Administration*, *supra*, at 195. Premium calculation based solely on experience rating generally is used only for large groups that previously have been insured and have a history of claims. *Id.* It also can be used to develop initial premiums for transferred business, as poor claims experience often is the reason for changing insurance companies.[4] *Group Benefits: Basic Concepts and Alternatives*, *supra*, at 255.

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4. In fact, some insurance companies refuse to write transferred coverage, particularly for large groups, unless the prospective policyholder provides verifiable prior claims experience. *Group Benefits: Basic Concepts and Alternatives*, *supra*, at 255.

In blended rating, premiums will be calculated in part through experience rating and, in part, through manual rating. This approach can be used where some claims experience for the particular group is available, but the information available is not adequate or sufficiently reliable to base the premium solely on the group's prior claims history. The portion of the premium that is based on experience rating will depend on the credibility the underwriter assigns to the group's prior claims experience. Typically, blended rating results in a premium lower than if calculated solely by manual rating, but higher than if calculated by experience rating alone. *Insurance Administration*, *supra*, at 196.

Although the foregoing is just a brief overview of the process by which premium rates are set, it serves to illustrate the comprehensive process by which insurers underwrite group policies in order to ensure that the premiums collected will be sufficient not only to cover valid claims incurred under the policy, but also to establish reserves in the event that actual claims experience exceeds anticipated claims, while still allowing for a reasonable contribution to the company's surplus.

3. Insurers Have Additional Safeguards Should Actual Claims Experience Exceed Anticipated Claims on Group Policies.

The assumption that paid claims necessarily detract from an insurer's profits is further undermined by the fact that insurers have a variety of tools they can utilize as safeguards against the risk that actual claims will exceed the claims anticipated in underwriting the group policy. One common method is rate adjustment. Group

policies generally are subject to annual renewal. When the policy is renewed, a new premium rate is calculated to reflect the group's expected claim experience for the coming year. Such rate is based on the group's claim experience from the prior year, as well as changes in the characteristics of the group, such as average age and gender ratios, and changes in benefit payments. Thus, if a group's actual claims experience for the prior year exceeds that anticipated in calculating the prior year's premiums, the insurer can increase the rate to cover excess claims.[5] *Id.* at 198. This prospective experience rating ensures that to the extent excess claims are incurred, any deficiency in the premium rate will be relatively short-lived. *See Pinto*, 214 F.3d at 388 n.6. (acknowledging that where an insurer adjusts premiums annually under an experience-rated formula, the incentive to deny claims in order to increase profits is lessened if not eliminated).

Retrospective experience rating is another tool that an insurer can use to limit its risk of excess claims, although such rating typically is used only with large groups. Under retrospective premium arrangements, a policyholder assumes some or all of the claim risk, often in exchange for lower up-front premium payments. At the close of the policy year, if actual claims experience exceeds that anticipated in calculating the premium rate, the insurer can collect additional premium from the policyholder. Conversely, if the claims experience is better than originally anticipated, a portion of the

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5. As an alternative to increasing rates, the insurer can suggest a revision to the coverage provided by the policy so that the coverage is adequately supported by the existing premium rate.

premium may be refunded, or alternatively maintained in a "rate stabilization reserve" to offset future fluctuations in that policyholder's claims experience. *Group Insurance*, 534, 545 (William F. Bluhm et al. eds., 3d ed. 2000). Retrospective experience rating therefore creates little financial incentive for an insurer to deny claims. *See Perlman*, 195 F.3d at 981 (retrospective rating eliminates financial interest); *Woo*, 144 F.3d at 1161 n.2 (noting that retrospective rating is not a funding conflict of interest warranting heightened review).

"Reinsurance" also enables an insurer to safeguard against the risk of excess claims by spreading risk to another insurer. Reinsurance in essence is the transfer of a specified risk from one insurer (called the ceding company) to a second insurer (called an assuming company). *Insurance Administration*, *supra* p. 10, at 202. There are various alternatives for specifying the risk to be transferred, including a set percentage of the coverage provided in the underlying policy (*e.g.*, 60% of a claim) and coverage that exceeds a predetermined threshold amount (*e.g.*, all claims in excess of $50,000). Under a stop-loss arrangement for reinsurance, the reinsurer agrees to pay claims that exceed a specified percentage of the total loss incurred above a threshold amount during a specified period and/or a maximum dollar amount. In the long term disability income insurance context, an extended-time arrangement may be utilized, whereby the reinsurer pays benefits after the ceding company has paid benefits for a specified period of time. *Id.* at 222-229.

Proper use of these mechanisms, in conjunction with effective underwriting practices in issuing the group policy, enable an insurer to minimize the risk it ultimately will

bear with respect to excess claims. Thus, the likelihood that excess claims arising under a particular policy could have any significant, negative impact on an insurer's bottom line is remote. The likelihood that a determination of any one particular claim could have such an impact is even more remote.

* * *

Accordingly, ACLI respectfully suggests that in light of the economic realities of the insurance industry, the mere fact an insurer both issues group insurance policies and employs claims personnel to determine claims simply does not establish an actual conflict of interest. Indeed, the alleged financial interest fairly may be considered not only remote, but also minute given the volume of claims an insurer typically handles. If such remote and minute financial interest can be deemed sufficient to create a conflict of interest, essentially any actor in the benefits process can be said to have a conflict of interest. One could also argue that an outside third party administrator hired by the sponsor of a self-funded plan has an economic interest in retaining its commercial relationship with the plan sponsor. Under this approach, taken to its logical conclusion, there are very few cases where courts would ever apply a traditional deferential review — a result which would be contrary to *Firestone*.

B. The Functional Organization And Regulation Of Insurers Preclude Employees Who Determine Claims From Wearing "Two Hats."

1. Benefit Determinations are Solely the Function of Claims Personnel.

The analogy that an insurer that both employs claims decisions personnel and pays benefit claims wears "two hats" is inapposite. The business of insurance involves various personnel who perform highly specialized and separate functions necessary for the provision of insurance. The claim management functions performed by claims employees, who render benefit decisions, are separate and distinct from those performed by the employees who design and market policies, the employees who underwrite policies, the employees who manage company reserves, and the employees who otherwise oversee the financial health of the company. Performance of these functions require separate skill sets. Moreover, insurers separate claim management functions from underwriting and other financial functions in order to avoid conflict of interest issues. Consequently, claims personnel wear only "one hat" — that of determining the validity of the claim.

Determining the validity of a claim is the primary concern of claim management personnel. "Claims management does not mean claims avoidance; nor is it merely a check writing facility to compensate any and all financial losses. The objective is to provide precisely the payment prescribed by the contract, no more and no less." *Group Insurance*, 367 (William F. Bluhm et al. eds., 3d ed. 2000). In performing that function, claims

personnel do not have access to information regarding the premium paid by a particular policyholder, the anticipated claims experience on which that premium is based or the level of actual claims as compared to the claims anticipated at the time the policy was underwritten.

2. In Rendering Benefit Determinations, Claims Personnel Must Comply With Regulatory Requirements Under Both ERISA And State Insurance Law.

In rendering benefit determinations and exercising claim management functions, claim personnel must adhere to regulatory requirements under both ERISA and state insurance law for proper processing of claims. These requirements serve to ensure that benefit claims are not improperly denied. ERISA imposes upon claim personnel a fiduciary duty to act not only in the interest of the claimant, but also the other beneficiaries of the plan when making claim determinations.

In addition to ERISA requirements, discussed *infra* at pp. 20-21, state regulation of insurance also protects beneficiaries' interest in proper claim management. (Pet'r Br. at 37-39.) As part of this regulatory regime, state regulators conduct "market conduct examinations" for the purpose of ensuring consumer protection and detecting improprieties in both claims handling procedures and in the substantive claims decision itself. Market conduct examinations are conducted on both a routine basis, as well as a target basis, such as when a company is the subject of unusually high consumer complaints. I National Association of Insurance Commissioners, *Market Conduct Examiners Handbook* 6 (2004).

As compared to the "macroscopic" focus of required financial examinations intended to assess the overall financial health and solvency of the insurer, the focus of market conduct examinations is "microscopic;" they are intended to detect management errors that may only have a small initial impact, but possibly could result in damaging long term effects. *Id.* at 1. Subjects routinely considered in a market conduct examination include operations/management, complaint handling, marketing and sales, policyholder service, underwriting and claims. *Id.* at 5. Through the use of sampling, a market conduct examiner reviews policies issued and declined, reviews claim handling practices, and directly determines how and why specific claims were handled as they were. *Id.* at 3.

The claims portion of a market conduct examination is designed to assess how the company treats claimants and whether that treatment is in compliance with applicable statutes, rules and regulations, and policy provisions. II National Association of Insurance Commissioners, *Market Conduct Examiners Handbook* 936 (2004). The claims portion of the examination includes a litigation survey to determine the extent of suits against an insurer, the basis for the suit, the company's position for denial or settlement offer, and whether bad faith judgments were rendered. *Id.* at 938. The claims portion of a market conduct examination for health and disability income products specifically includes a review of the company's claim procedure and claims training manual. It also includes, *inter alia*, a review to determine whether investigations are conducted in a timely manner, *id.* at 942; whether investigations to determine liability are fair and

reasonable, *id.* at 951; whether claim files are handled in accordance with policy provisions and state law, *id.* at 950; whether claim file documentation is sufficient to support or justify the actual claim determination, *id.* at 948; and, most significantly, whether claims handling practices compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies, *id.* at 957.

C. ERISA Contemplates That Plan Fiduciaries May Both Make Benefit Determinations And Fund The Benefits Paid.

ERISA itself contemplates and expressly permits plan fiduciaries to both make benefit determinations and fund the benefits paid. 29 U.S.C. § 1108(c)(3). It also imposes requirements that ensure the protection of a beneficiary's interests and that the beneficiary is provided information necessary to dispute an adverse claims decision, including the possibility that a benefits decisions may have been improperly motivated.

The regulations implementing ERISA establish a strict and comprehensive regulatory framework to govern the claims process and any resulting benefit disputes. 29 C.F.R. § 2560.503-1. These regulations require, *inter alia*, that:

- The claimant must be provided with written or electronic notification of an adverse benefit determination which sets forth the specific reason(s) for the adverse determination, references the specific plan provisions on which the determination is based, describes any

additional information necessary for the claimant to "perfect" the claim, and explains why such information is necessary. *Id.* § 2560.503-1(g)(1).

- The claimant must have an opportunity within the plan to appeal an adverse benefit determination, and the appeal procedures must provide a "full and fair" review. *Id.* § 2560.503-1(h)(1).

- The notice of an adverse benefit determination must describe the plan's review procedures, the time limits applicable to these review procedures and state the claimant's right to bring a civil action under ERISA if an adverse determination is issued on review. *Id.* § 2560.503-1(g)(1)(iv).

In order to ensure that the claimant is provided a "full and fair" review, the plan's internal appeal procedures must, at a minimum, provide the following:

- The internal appeal must be decided by a fiduciary who is not the initial claim reviewer (or a subordinate of such person). *Id.* §§ 2560.503-1(h)(3)(ii), -1(h)(4).

- The appeal cannot give deference to the original claim decision (i.e. the internal appeal is reviewed *de novo*). *Id.* §§ 2560.503-1(h)(3)(ii), 1(h)(4).

- The claimant must have a right of access to certain specific information relevant to the benefit claim. *Id.* §§ 2560.503-1(h)(2)(iii), -1(h)(4). With respect to disability benefit claims, upon request, the plan also must provide the claimant with the identity of

any medical or vocational experts consulted on the claim, irrespective of whether the expert's advice was relied upon in making the determination. *Id.* §§ 2560.503-1(h)(3)(iv), -1(h)(4).

- The claimant must have an opportunity to submit additional information and/or written comments, and the review must consider all additional information submitted by the claimant, irrespective of whether it was submitted or considered during the initial benefit determination. *Id.* §§ 2560.503-1(h)(2)(ii), -1(h)(2)(iv), -1(h)(4).

- With respect to disability benefits claims, where the benefit denial is based on medical judgment, the fiduciary reviewing the determination must consult with an appropriate health care professional. The health care professional consulted during the review cannot be an individual consulted with respect to the initial determination (nor the subordinate of any such individual). *Id.* §§ 2560.503-1(h)(3)(iii), -1(h)(3)(v), -1(h)(4).

- The claimant must be provided with written or electronic notification of the determination on review which sets forth the specific reason(s) for the adverse determination, the specific plan provisions on which the determination is based, and the claimant's right to request all documents and information relevant to the claim. *Id.* § 2560.503-1(j).

- With respect to disability benefit claims in which the plan relies upon an internal rule, guideline, protocol or other similar criterion in making the adverse determination, notice of both the initial determination and the determination upon review also must either include such internal rule, guideline, protocol or other similar criterion, or state that a copy will be provided free of charge upon request. *Id.* §§ 2560.503-1(g)(1)(v)(A), 1(5)(i).

The claims process mandated by these regulatory requirements ensures that a beneficiary will have appropriate information necessary to challenge the decision of an ostensibly conflicted decision-maker.

II. IF AN INSURER IS DEEMED TO OPERATE UNDER A CONFLICT OF INTEREST MERELY BECAUSE IT BOTH PROVIDES CLAIM ADMINISTRATION SERVICES AND PAYS CLAIMS, A TRADITIONAL DEFERENTIAL STANDARD OF REVIEW SHOULD APPLY ABSENT A SHOWING THAT THE CONFLICT ACTUALLY INFLUENCED THE BENEFIT DETERMINATION.

ACLI respectfully submits that benefit determinations rendered by administrators or fiduciaries who are contractually afforded discretion by the terms of the plan, but also pay claims in addition to rendering the benefit determinations, should be reviewed under a traditional deferential standard of review, absent some showing that the potential conflict of interest actually influenced the benefit determination. The Court suggested in *Firestone* that a conflict of

interest is to be "weighed" in determining whether there has been an *abuse of discretion.* 489 U.S. at 115 (emphasis added) (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)). Cleary, this statement means only that a court must consider the conflict in assessing whether there has been an abuse of discretion — not that the standard of review itself should be altered. Any other interpretation would be inconsistent with the common law of trusts, upon which *Firestone* is predicated. Under the common law of trusts, the abuse of discretion standard is not altered merely because a trustee is operating under an apparent conflict of interest. Rather, it must be shown that the trustee's decision was *affected* by that conflict. A court will not interfere with a trustee's exercise of discretionary power unless the trustee

> acts dishonestly, or with an improper even though not a dishonest motive, or fails to use his judgment or acts beyond the bounds of a reasonable judgment. The mere fact that . . . the court would have exercised the power differently, is not a sufficient reason for interfering with the exercise of the power by the trustee.

Restatement (Second) of Trusts § 187 cmt. e (1959). Accordingly, a court may "weigh" the existence of a conflict of interest, but should still apply a traditional deferential standard of review unless there is sufficient evidence to establish that the conflict affected the claims decision.

The various alternate approaches adopted by the Circuits essentially determine the standard of judicial review based on the identity of the administrator or fiduciary rather than whether the purported conflict actually was acted upon. There is no persuasive rationale why the identity of the decision-maker should determine the standard of review. ERISA itself both contemplates and permits a plan administrator or fiduciary to make claims decisions even though that party may be financially affected by the outcome of the decision, 29 U.S.C. § 1108(c)(3), and imposes safeguards to ensure that the interests of plan beneficiaries are adequately protected. Furthermore, as the Court suggested in *Firestone*, the appropriate standard of review under ERISA derives from trust law, wherein fiduciary responsibility is not equated with impartiality. 489 U.S. at 115. When the benefit plan grants entities discretion to make benefit determinations, federal courts should not negate the grant of discretion by altering the standard of review based on the mere potential for a conflict of interest.

The various other approaches to the applicable standard of review, such as the "sliding scale" approach, the "presumptively void" approach or even *de novo* review, are problematic in that nothing in *Firestone*, or in trust law to which the Court analogized in *Firestone*, suggests that the mere potential for a conflict of interest should affect the standard of review where discretion has been granted. Application of a *de novo* standard of review is particularly problematic, as there is no suggestion in *Firestone* that a potential conflict actually negates a grant of discretion. The "sliding scale" approach does not provide sufficiently clear guidance to

lower courts attempting to apply the standard of review. Circuits following this approach often essentially wind up applying a *de novo* standard of review, even though the Court declined to adopt this approach in *Firestone*. The uncertainty engendered by this approach also is problematic because it undermines Congress' key objective in enacting ERISA – to establish a "uniform administrative scheme" for ERISA-covered benefit plans and a uniform body of federal common law for enforcement of such plans. *Fort Halifax Packing Co. v. Coyne, Inc.*, 482 U.S. 1, 9 (1987). Congress sought to establish this uniformity as part of its effort to encourage employers to establish benefit plans by eliminating the difficulties presented by and increased costs resulting from a patchwork of conflicting state and local laws.

Finally, the alternate approaches also undervalue the role that deference plays in the formation of benefit plans. Upholding a plan's grant of discretionary authority through application of a deferential standard of review provides plan sponsors with a degree of contractual control over the benefit plan and promotes its affordability. [6] ERISA does not mandate what, if any,

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6. Nationwide, the rapidly rising cost of health insurance premiums has far outpaced wage growth and inflation for some time now. *See, e.g., The Uninsured and Rising Health Insurance Premiums: Hearing Before the Subcomm. On Health of the H. Ways & Means Comm.* 108th Cong. 108-50 (Mar. 9, 2004) (Statement of Douglas Holtz-Eakin, Director, Congressional Budget Office). Given that increasing litigation, large awards, and class actions are among the major drivers of increasing insurance costs, *see* PriceWaterhouseCoopers for the American Ass'n of Health Plans, *The Factors Fueling Rising Healthcare Costs* 9 (2002) *cited in* Governor's Task Force on Access to Affordable Health Insurance, (Cont'd)

benefits an employer must provide and employers have large leeway to design their plans. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). Given the enormously wide range of issues that can arise in rendering benefit decisions under any plan, it is not possible to predict every type of issue and claim that may arise. Discretion and a deferential standard of review enable the plan to resolve such issues in a manner that best protects the interests of all participants in the plan and reduce the danger that the outcome will be strongly influenced by unusual facts that may be present in a particular case.

Accordingly, in the absence of an actual conflict of interest and where the states are already well-empowered to address and remedy inappropriate claims administration, the marginal benefits of *de novo* or "sliding scale" review to the average employee are minimal at best. The traditional deferential approach is the most appropriate approach, and there is no legal or economic justification for change.

(Cont'd)

Final Report 30 (Feb. 15, 2004), *available at* http://www.fdhc.state.fl.us/affordable_health_insurance/PDFS/task_force_report_021504_final.pdf, permitting *de novo* or "sliding scale" judicial review on the basis of perceived and not actual conflicts of interest is far from Congress' intent in enacting ERISA to promote the formation and uniform regulation of employee benefit plans.

CONCLUSION

For the foregoing reasons, ACLI respectfully submits that the mere fact a claims administrator both renders claims decisions and pays claims does not constitute a conflict of interest sufficient to affect the standard of judicial review applicable to that benefit determination.

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